

The Norwegian Mother and Child Study

Questionnaire 4 – Child aged 6 months

This is a two part questionnaire. The first part is about your child while the second part is about you. The information on your child's health card will be useful when answering the questionnaire. Skip any questions that are difficult to answer and continue with the next question.

Please complete one questionnaire for each child if you have twins or triplets.

This questionnaire will be processed by a computer. It is therefore important that you follow these instructions:

- Please use a blue or black ballpoint pen.
- Put a cross in the box that is most relevant like this: X
- Should you put a cross in the wrong box correct it by filling in the box completely like this: ■
- In the large green boxes write a *number* or a *capital letter*

It is important that you only write in the white area of each box like this:

Number:

- When filling in a single figure in boxes containing two or more squares please use the square to the right. For example: 5 is written like this:
- Boxes for dates are divided in three parts. The first box is for the day, the second for the month and the last for the year. For example: 6 May 2002 is written like this: day/month/year
- Specific information concerning medication should be written on the lines provided. Please write clearly in CAPITAL LETTERS.

Please return the completed questionnaire in the stamped addressed envelope provided.

Date on which the questionnaire was completed: Day, month and year (write the year with 4 numbers, ex. 2002)

Question	Answer
The birth	
1. Is your child a boy or girl?	Boy/ Girl
2. What was the weight and length of your child at birth?	Birth weight: g/ Length: cm
3. During which week of pregnancy did you give birth?	Week
4. How long was your child at the hospital after birth?	Number of days or weeks
5. Was your child transferred to a different department or hospital after birth?	No/ Yes/ If yes, which? _____
6. Was your child born by Cesarean section?	No/ Yes
7. If yes, was the Cesarean section planned? If yes, why?	No/ Yes Breech position/ Previous Cesarean section/ Complications during pregnancy or mother's illness/ Poor growth or other condition of the fetus/ Personal wish/ Other

8. Did any complications develop during the birth?	No/ Yes/ If yes, describe the complications:_____
9. Were you admitted or transferred to a different department or hospital due to complications during the birth? (Applies to both before and after birth.)	No/ Yes
10. If yes, where?	Department:_____/ Hospital:_____
11. How long were you at the hospital in connection with the birth?	Before birth Number of days/ After birth Number of days
12. Was the birth experience as expected?	Yes, as expected/ No, it was easier/ Both yes and no/ No, it was worse/ Don't know
13. How do the following statements describe your experience during the birth? (Fill in each line.)	Agree/ Agree somewhat/ Disagree I felt secure and in good hands/ I had a lot of pain/ I received too little medicine for the pain
14. Were any of your relatives/close friends with you during the birth?	Yes, the child's father/ Yes, others/ No
Your child	
Nutrition	
15. What did your child drink during the first week after birth? (Fill in all correct answers.)	Breast milk/ Water/ Sugar water/ Formula/ Other: describe_____/ Don't know/ Do not remember

16. What kinds of milk does your child drink? <i>(Fill in one or several boxes for each month.)</i>	<i>The child's age in months</i> Milk type Breast milk/ Collett regular/ Collett with Omega 3/ NAN regular/ Nan HA1/ Other milk, describe: _____
17. How often does your child currently drink the following fluids? <i>(Fill in each line.)</i>	<i>Never or infrequently/1-3 times a week/4-6 times a week/At least once a day</i> 1. Breast milk/ 2. Formula/ 3. Regular sweet milk, all types/ 4. Sour milk (yogurt, culture milk, etc.)/ 5. Ecological milk products (milk, yogurt)/ 6. Boiled water/ 7. Tap water/ 8. Bottled water/ 9. Bottled nectar (squash) for children/ 10. Other nectar (squash) with sugar/ 11. Nectar (squash) with artificial sweetener/ 12. Juice/ 13. Other, describe: _____
18. How often does your child currently eat the following foods and how old was the child when he/she started with these foods?	<i>How often does the child eat this?</i> <i>Never or infrequently /1-3 times a week/ 4-6 times a week/ At least once a day</i> <i>How old was the child when he/she ate this food the first time?</i> <i>Months old</i> Commercially manufactured porridge (porridge powder): 1. Rice porridge, corn porridge/ 2. Oatmeal, different types/ 3. Wheat porridge, all types, rusk porridge Homemade porridge of: 4. Wheat flour (whole wheat/white), rusk, semolina, oatmeal/ 5. Wheat flour with iron additives/ 6. Helios child flour/ 7. millet Commercially manufactured dinner in jars: 8. Vegetables/ 9. Vegetables and meat Homemade dinner: 10. Mashed potatoes/vegetables/ 11. Meat and vegetables/potatoes/ 12. Fish and vegetables/potatoes/ 13. Other homemade dinner Snacks/dessert: 14. Homemade mashed fruits/ 15. Manufactured mashed fruits/berries in jars/ 16. Rusk/crackers/bread/ 17. Other, describe: _____

19. Do you believe or know that your child has an adverse reaction to milk/milk products?	No/ Yes
20. If yes, which products?	Whole milk/ Light milk/skimmed milk/ Cream/whipped cream/ice cream/ Yogurt/sour milk/ Breast milk when the mother drinks milk/ Other
21. Does your child take cod liver oil, vitamins, iron supplement or other nutritional supplements?	No/ Yes
22. If your child takes cod liver oil, vitamins, iron supplement or other nutritional supplements, put a cross in the box for the appropriate product, how much the child takes each time and how often. How old was your child the first time he/she took the product?	<p><i>How much each time?</i> <i>teaspoons</i> <i>How often does your child take this?</i> <i>daily on and off</i> <i>How old was your child when you started with these products?</i> <i>months weeks</i> 1. Cod liver oil/ 2. Biovit/ 3. Sanaol/ 4. Collet vitamins for infants/ 5. Fluoride/ 6. Iron supplement, which: _____/ 7. Other nutritional supplements, which: _____</p>
Growth, health and medication	
The answers to the questions in this section may be found on you child's health card.	
23. How many times have you been to the health clinic with your child?	Never/ 1-2 times/ 3-5 times/ 6-10 times/ More than 10 times

24. Has your child received the vaccines recommended by the health clinic?	Yes/ No, I do not want the vaccines/ No, the child has been frequently ill/ No, vaccination has been postponed for practical reasons/ I don't know
25. Using your child's health card as the source of information cross off the vaccines your child has received and if the vaccines have given any side effects. (Fill in each line.)	<i>Has the child received this vaccine? No/ Yes</i> <i>Have there been any side effects from the vaccine? No/ Yes</i> <i>Have there been any side effects that required medical attention? No/ Yes</i> <i>Have there been any side effects that required hospitalization? No/ Yes</i> 1. DTP (Infanrix)/ 2. DT (Diphtheria/tetanus)/ Polio-Hib (Act-Hib polio)/ Hepatitis B (Enerix-B)/ BCG (Tuberculosis)/ Other vaccines: _____
26. Use your child's health card as the source of information and enter your child's weight, length and head circumference when the child was approximately 6 weeks, 3 months and 6 months of age:	<i>Date of examination/ day/ month/ year/ weight(/ Length/ Head circumference</i> Ca. 6 weeks/ ca. 3 months/ Ca. 6 months
27. Does your child have/has had any of the following health problems. If yes, has the health clinic or other referred your child to a specialist for additional examination? (Fill in each line.)	<i>Has the child had this problem? No / Yes</i> <i>Has the child been referred to a specialist? No/ Yes, referred from the health clinic/ Yes, referred from other</i> 1. Hips/ 2. Hearing/ 3. Sight/ 4. Delayed motor development/ 5. Too slow increase in weight/ 6. Too fast increase in weight/ 7. Head circumference divergence/ 8. Cardiac failure/ 9. Undescended testes/ 10. Asthma/ 11. Atopic (child) eczema/ 12. Urticaria/ 13. Food allergy/intolerance/ 14. Other malformation: _____ / 15. Other: _____
28. If your child was referred to a specialist, what were the results of this examination?	Everything was normal/ Uncertain diagnosis/further investigation/ Do not know/ Have received following diagnosis: _____
29. Has your child been treated with a "pillow" placed between the legs for a hip problem?	No/ Yes/ How long? _____ months
30. Has your child had the following illnesses/health problems? If yes, did you visit a doctor or hospital? (Fill in each line.)	<i>Has the child had health problems? No/ Yes</i> <i>How many times</i> <i>Did you visit a doctor/clinic for this? No/ Yes</i> <i>Has the child been admitted to a hospital for this? No/Yes</i> 1. Cold/ 2. Throat infection/ 3. Ear infection/ 4. Laryngitis/ 5. Bronchitis/RS-virus/Pneumonia/ 6. Stomach infection/diarrhea/ 7. Urinary tract infection/

	8. Eye infection/ 9. Fever seizures/ 10. Other seizures (without fever)/ 11. Colic/ 12. Diaper rash/ 13. Other, describe:_____
31. Has your child ever taken medicines?	No/ Yes
32. If yes, give the name of the medicine(s) and when the medicine(s) was/were taken. <i>(Include all medicines, alternative and herbal remedies, both regular and occasional use.)</i>	<i>Name of the medicine (For example Apocilin, Paracetamol)_____</i> <i>How old was the child when the medicine was taken?</i> > 1 month/ 1-2 months/ 3-4 months/ 5-6 months/ Number of days taken in total
33. Has your child been examined or admitted to a hospital (after you came home from the hospital following the birth)?	No/ Yes, which hospital:_____
34. Has your child been operated or have a condition that requires surgery?	No/ Yes, which:_____

Development, child care and life style	
35. The following questions concern your child's development. If you have not noticed, take some time to see what your child actually does. <i>(Fill in each line.)</i>	<i>Yes, often/ Yes, infrequently/ No, not yet/ Don't know</i> 1. Does your child play with his/her feet when lying on his/her back?/ 2. Does your child lift his/her body from the floor with straight arms when lying on his/her stomach?/ 3. Does your child roll over from his/her back to stomach?/ 4. When you talk to your child does he/she try and talk with you?/ 5. Does your child babble and make sounds when he/she lies alone?/ 6. Do you know how your child feels by listening to the sounds he/she makes <i>(for example satisfied, hungry, angry, in pain)?</i> / 7. Does your child smile at you when you smile at him/her <i>(without touching or tickling the child and without showing him/her a toy)?</i> / 8. When you call your child does he/she turn toward you one of the first times you say his/her name?/ 9. When you give your child a toy does he/she hold it or put the toy in his/her mouth?/ 10. Does your child reach for a toy or something else that is on the table in front of you when he/she sits on your lap?/ 11. When your child examines a toy

	does he/she hold it with both hands?
36. Where is your child care during the day?	At home with mother/father/other family member/ At home with a baby sitter/ With a baby sitter/child minder/ Family kindergarten/ Kindergarten
37. How many children is your child usually together with during the day?	children
38. Does your child participate in baby swimming?	No/ Yes/ If yes, give the number of times during the past 2 months
39. How often is your child outdoors?	Infrequently/ Frequently, but less than 1 hour a day/ 1-3 hours a day/ More than 3 hours a day
40. Does your child use a pacifier?	Infrequently or never/ Only when he/she shall sleep/ Frequently/ Most of the time
41. How many hours in total does your child sleep every day?	Less than 8 hours/ 8-10 hours/ 11-12 hours/ 13-14 hours/ More than 14 hours
42. How is your child laid down to sleep? <i>(Fill in each line.)</i>	<i>On the back/ On the side/ On the stomach</i> Immediately after birth/ At 2 months of age/ At 4 months of Age/ At 6 months of age
43. Does your child sleep (at least half of the night) in the same bed as the mother/father? <i>(Fill in each line.)</i>	<i>No/ Sometimes/ Frequently</i> Immediately after birth/ At 2 months of age/ At 4 months of Age/ At 6 months of age
44. Indicate whether or not you agree or disagree with each of the following assertions about your child's usual humor and temperament. <i>(Fill in each line.)</i>	<i>Disagree completely/ Disagree/ Disagree somewhat/ Don't agree or disagree/ Agree somewhat/ Agree/ Agree completely</i> 1. The child whimpers and cries a lot/ 2. The child is usually easy to console when he/she cries/ 3. The child is easily upset and begins to cry/ 4. The child usually screams angrily and loudly when he/she cries/ 5. The child is easy to get along with/ 6. The child demands a lot of attention/ 7. The child usually plays well alone when left to himself/herself/ 8. Then child is so demanding that he/she would be a considerable problem for most parents/ 9. The child smiles and laughs frequently/ 10. The child is easy to put to bed and falls asleep quickly

45. How often does your child wake up at night at present?	3 or more times every night/ 1-2 times every night/ A few times a week/ Infrequently or never
Comments	
About you	
Heath and use of medication	
46. Did you visit a doctor/midwife/public health nurse for your own health problems during the first months after the birth?	No / Yes, times
47. If yes, what was the reason?	Sore/stitches near the vaginal opening/ Sore at the Cesarean section incision/ Breast inflammation/ Sore nipples/ Problems with nursing/ Other, describe:_____
48. Did you feel depressed following the birth?	No/ Yes, how long: weeks
49. Have you been admitted to a hospital after you completed the previous questionnaire except when you were at the hospital to give birth?	No/ Yes, which hospital:_____
50. Do you have a chronic/prolonged illness that developed after you completed the previous questionnaire?	No/ Yes, which:_____
51. Everything considered, how would you describe your physical health at present?	Very good/ Good/ Poor/ Very poor
52. Have you had any of the following discomforts/illnesses since you completed the previous questionnaire? If yes, do you or have you used medicines for these conditions? (<i>This applies to all types of medicines including alternative and herbal remedies, both regular and occasional use.</i>) (<i>Fill in each line.</i>)	<i>Have you suffered from?/ If you have taken medicines</i> <i>Discomfort/illness</i> <i>No/ Yes, the last part of the pregnancy/Yes, after the birth</i> <i>Name of medicines taken</i> <i>Last part of the pregnancy/ After the birth/ 0-3 months/ 4-6 months/ Number of days in total medicine taken</i> 1. Sugar in urine/ 2. Albumin (protein) in urine/ 3. High blood pressure/ 4. Swelling (oedema)/ 5. Bladder infection/ 6. Constipation/ 7.

	Diarrhea/stomach infection/ 8. Heartburn/reflux/ 9. Common cold/influenza/ 10. Throat-/sinus-/ear infection/ 11. Pneumonia/bronchitis/ 12. Asthma/ 13. Hay fever/other allergy/ 14. Headache/other pain/ 15. Vaginal thrush/ 16. Psychological difficulties/ 17. Breast inflammation/ 18. Fever/ 19. Other, describe:_____
53. Have you taken medicines other than those named in question 52? (<i>For example, sleeping tablets, sedatives, pain killers.</i>)	No/ Yes
54. If yes, give the name of the medicine(s) and when the medicine(s) was/were taken. (<i>Include all medicines, alternative and herbal remedies, both regular and occasional use.</i>)	<i>Name of the medicine (For example Valium, Rohypnol, Paracetamolamol)_____</i> <i>Last part of the pregnancy/ 0-3 months after the birth/ 4-6 month after the birth</i> Took medicine/ Number of days
55. Do you take or have you taken cod liver oil, vitamins or other nutritional supplements since you completed the previous questionnaire?	No/ Yes
56. If yes, which product, when did you take it and how often? (<i>Fill in one line for each product.</i>)	<i>Name of product</i> <i>When the product was taken</i> Last part of the pregnancy/ 0-3 months after the birth/ 4-6 month after the birth
57. Have you had back or pelvic pains after completing the previous questionnaire?	No (<i>proceed to question 63</i>)/ Yes
58. If yes, fill in a box for each condition, when you experienced the discomfort and the degree of pain.	<i>Where was the pain?</i> <i>Last part of the pregnancy/ 0-3 months after the birth/ 4-6 month after the birth</i> Small of the back/ One of the pelvic joints on the backside/ Both of the pelvic joints on the backside/ Tailbone/ In the buttocks/ Front of the pelvis/ Groin/ Other back pains
59. Do you wake up at night due to pelvic pain at present?	No, never/ Yes, infrequently/ Yes, frequently
60. Do you have to use a cane or crutches in order to walk due to pelvic pain?	No, never/ Yes, but not every day/ Yes, every day

61. Have you <i>ever</i> received treatment for pelvic pain?	No/ Yes
62. If yes, cross off which type of treatment and when.	<i>Before this pregnancy/ During this pregnancy/ After this birth</i> Physiotherapy/ Chiropractic therapy/ Medication / Other, describe:_____
63. When did you resume sexual intercourse after the birth?	_____ weeks Have not had intercourse
64. Do you have at present any of the following problems, how often and how much? (<i>Fill in each line.</i>)	<i>How often do you experience discomfort?</i> Never/ 1-4 times a month/ 1-6 time a week/ 1 time a day/ more than once a day <i>How much every time?</i> Drops/ Larger volumes Incontinence when coughing, sneezing, laughing/ Incontinence with physical exertion (running/jumping)/ Incontinence with strong urge/need to urinate/ Problem with controlling bowel movements/ Problem with controlling gas
65. How many times did you have an ultrasound examination during the pregnancy?	_____ times
66. Were the results of the ultrasound examinations normal?	Yes (proceed to question 68)/ No
67. If no, what was the problem?	The child grew too slowly/ Suspicion of malformation, describe:_____/ Other, describe:_____
68. What was your weight at the end of the pregnancy and what is your weight now?	At the end of the pregnancy _____ kg/ Now _____ kg
69. Were you on part- or full-time medical leave after the 30 th week of pregnancy?	No (proceed to question 71)/ Yes, part-time medical leave/ Yes, full-time medical leave
70. Complete the table below if you were on medical leave after the 30 th week of pregnancy. Use one line for each medical leave, give the reason and in which weeks you were on leave. Give the number of days and the percent of each medical leave.	<i>Reason for medical leave:</i> Example: Pelvic relaxation <i>Medical leave during weeks:</i> 30-33/ 34-37/ 38+/ Number of days/ % medical leave
Economy and life style	
71. Is your economy so good that you would be able to pay an unexpected bill of 3,000 Norwegian Crowns (USD 400) for example, for a dental or repair bill?	No/ Yes/ Don't know

72. During the past 6 months have you had difficulty covering your monthly expenses for food, transportation, rent, etc.?	No, never/ Yes, occasionally/ Yes, sometimes/ Yes, frequently
73. Are there any pets in the child's home?	No/ Yes
74. If yes, which pets?	Dog/ Cat/ Guinea pig, rabbit, mouse, rat, etc./ Canary, other bird/ Other pet: _____
75. Do you have electrically heated floors in the rooms used by the child?	No/ Yes
76. If yes, in which rooms?	Living room/ Kitchen/ Playroom/ Bedroom/ Hall/ Bathroom/ Other room
77. How often do you do exercises for the following groups of muscles? (Fill in each line.)	<i>Never/ 1-3 times a month/ Once a week/ Twice a week/ 3 or more times a week</i> Abdominal muscles/ Back muscles/ Pelvic floor muscles (Muscles around the vagina, urethra, anus)
78. How often do you usually exercise at the present time? (Fill in each line.)	<i>Never / 1-3 times a month / Once a week / Twice a week / 3 times or more a week</i> 1. Walking/ 2. Brisk walking/ 3. Running/jogging/cross-country running/ 4. Bicycling/ 5. Training studio/weight training / 6. Special gymnastics/aerobics for pregnant women/7. Aerobics/gymnastics/dance without running and jumping/ 8. Aerobics/gymnastics with running and jumping/ 9. Dancing (swing/rock/folk)/ 10. Skiing/ 11. Team sports/ 12. Swimming/13. Riding/14. Other
79. How often are you currently so physically active in your leisure and/or at work that get out of breath or sweat? (Fill in for both leisure and work.)	<i>Leisure/ At work</i> Never/ Less than once a week/ Once a week/ Twice a week/ 3-4 times a week/ 5 or more times a week
80. What was your and your partner's/husband's smoking habits during the last 3 months of the pregnancy and in the time following the birth? (Fill in for each period)	<i>You/ Your partner/husband</i> <i>Last 3 months of pregnancy/ 0-3months after birth/ 4-6 months after birth</i> Never smoked/ Smoked occasionally/ Smoked daily
81. Is the child in a room where people smoke?	No/ Yes, sometimes/ Yes, many times a week/ Yes, daily If yes, how many hours a day

82. Have you used any of the following substances during the last 3 months of the pregnancy and after the birth? <i>(Fill in each line.)</i>	<i>No/ Yes, last 3 months of pregnancy/ Yes, after birth</i> Hash/ Amphetamine/ Ecstasy/ Cocaine/ Heroin/ Other, describe:_____
83. Have you used any of the following substances during the last 3 months of the pregnancy and after the birth? <i>(Fill in each line.)</i>	<i>No/ Yes, last 3 months of pregnancy/ Yes, after birth</i> Anabolic steroids/ Testosterone products/ Growth hormones (ex. Genotropin/Somatropin)
84. How often did you drink alcohol during the last 3 months of the pregnancy and after the birth? <i>(Fill in for each period.)</i>	<i>Last 3 months of pregnancy</i> <i>After birth</i> <i>0-3 months/ 4-6 months</i> Approx. 6-7 times a week/ Approx. 4-5 times a week/ Approx. 2-3 times a week/ Approx. once a week/ Approx. 1-3 times a month/ Less than once a month/ Never
Alcohol units are used to compare the different types of alcoholic beverages. 1 alcohol unit = 1.5 cl. pure alcohol. 1 beer glass of beer = 1 alcohol unit 1 wine glass red or white wine = 1 alcohol unit 1 wine glass sherry or other fortified wine = 1 alcohol unit 1 snaps glass spirits or liqueur = 1 alcohol unit 1 bottle/can energy drink or cider = 1 alcohol unit	
85. How many units of alcohol do you usually consume when you drink alcohol (complete for the last 3 months of the pregnancy and after)? <i>(See explanation of alcohol units above.) (Fill in for each period)</i>	<i>Last 3 months of the pregnancy</i> <i>After the birth</i> <i>0-3 months/ 4-6 months</i> 10 or more / 7-9 / 5-6 / 3-4 / 1-2 / Less than 1
You and your feelings	
86. Do you have a partner/husband?	Yes/ No
87. If yes, how do these statements describe your situation? <i>(Fill in only one box per line.)</i>	<i>Agree completely/ Agree/ Agree somewhat/ Disagree somewhat/ Disagree/ Disagree completely</i> My husband/partner and I have a close relationship/ My partner and I have problems in our relationship/ I am very happy with our relationship/ My

	<p>partner is usually understanding/ I often think about ending our relationship/ I am satisfied with my relationship with my partner/ We often disagree about important decisions/ I have been lucky in my choice of a partner/ We agree about how our child should be raised/ I think my partner is satisfied with our relationship</p>
88. How often do you experience the following in your everyday life? <i>(Fill in only one box per line.)</i>	<p><i>Almost never/never/ Infrequently/ Sometimes/ Frequently/ Very often</i> Feel happy about something/ Feel lucky/fortunate/ Feel optimistic, as though everything falls in place for you/ Feel that you will scream at someone or break something/ Feel angry, irritated or annoyed/ Feel furious with someone</p>
89. Do you agree or disagree with the following statements? <i>(Fill in only one box in each line.)</i>	<p><i>Disagree completely/ Disagree/ Disagree somewhat/ Don't agree or disagree/ Agree somewhat/ Agree/ Agree completely</i> My life is largely what I wanted it to be/ My life is very good/ I am satisfied with my life/ To date, I have achieved what is important for me in my life/ If I could start all over, there is very little I would do differently</p>
90. Have you experienced any of the following since completing the previous questionnaire? If yes, how painful or difficult was it for you? <i>(Fill in each line.)</i>	<p><i>No/ Yes</i> <i>If yes</i> <i>Not too bad/ Painful/difficult/ Very painful/difficult</i> Have you had problems at work or where your study/ Have you had financial problems/ Have you been divorced, separated or ended your relationship with your partner/ Have you had problems or conflicts with your family, friends or neighbors/ Have you been seriously concerned that something was wrong with your child/ Have you been seriously ill or injured/ Have any of your relatives or friends been seriously ill or injured/ Have you been involved in a serious accident, fire or robbery/ Have you lost someone close to you/ Have you been forced to have sex/ Other</p>
91. Have you had any of the following feelings during the last week? <i>(Fill in only one box in each line.)</i>	<p><i>Yes, almost all the time/ Yes, sometimes/ Not very often/ No, never</i> Blamed yourself without any reason when something went wrong/ Been nervous or worried without reason/ Been frightened or experienced panic without reason/ Been so unhappy that you have had sleeping problems/ Felt down or unhappy/ Been so unhappy that you have cried</p>
92. How do you feel about yourself? <i>(Fill in only one box in each line.)</i>	<p><i>Agree completely/ Agree/ Disagree/ Disagree completely</i> I have a positive attitude toward myself/ I feel completely useless at times/ I</p>

	feel that I do not have much to be proud about/ I feel that I am a valuable person, as good as anyone else
93. Have you been bothered with any of the following during the past 2 weeks? (<i>Fill in only one box in each line.</i>)	<i>Not bothered/ A little bothered/ Quite bothered/ Very bothered</i> Constantly frightened or anxious/ Nervous, inner turmoil/ Feeling of hopelessness with regard to the future/ Depressed, sad/ Frequently worried or uneasy/ Feeling of hardship/ Feel tense or stressed/ Sudden fear without reason

Thank you very much for your help!

Please return the completed questionnaire in the stamped addressed envelope provided.